STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	04/21/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTH AT WINDERMERE	9745 OLYMPIA DRIVE FISHERS, IN46038

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R0000	This visit was for a State Residential Licensure survey. This visit included the investigation of Complaint Number IN00086625. Complaint Number IN00086625: Substantiated. State Residential deficiency related to the allegations is cited at R306 Survey dates: April 18, 19, 20, and 21, 2011 Facility Number: 002999 Provider Number: 002999 AIM Number: N/A Survey team: Janet Stanton, R.N.--Team Coordinator Michelle Hosteter, R.N. Rita Mullen, R.N. (4/18, 19) Census bed type: Residential--114 Total--114 Census payor type: Other--114 Total--114 Residential sample: 10	R0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	These Residential State findings are cited in accordance with 410 IAC 16.2-5. Quality review completed 4-28-11 Cathy Emswiller RN			
R0155	(l) The facility shall have an effective garbage and waste disposal program in accordance with 410 IAC 7-24. Provision shall be made for the safe and sanitary disposal of solid waste, including dressings, needles, syringes, and similar items. Based on observation and interview, the facility failed to ensure the facility dumpster was closed in order to prevent potential spillage of trash, for 1 of 1 dumpster that served the facility in 2 of 3 observations on 4/19 and 4/21/11. Findings include: On 4/19/11 at 9:30 A.M., the facility dumpster was observed positioned on the opposite side of the parking lot, at the back of the main building. The front door surrounding dumpster was open, and both top panels of the dumpster were open. Plastic bags of trash were observed stacked inside up to the top of the dumpster. On 4/21/11 at 1:42 P.M., the dumpster was observed with the front door open, and the top panels were open. At 2:10 P.M., the refuse company was observed	R0155	Housekeeping and Food Service staff will be inserviced instructing them to make sure the dumpster lid is closed each time they take out trash. Inservice will be done by May 20, 2011. Maintenance supervisor will check the dumpster lid each day during daily rounds to make sure it is closed. Food Service Director will check the dumpster several times a week upon entering and exiting the building to ensure the lid is closed.	05/21/2011

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	emptying the dumpster and leaving the dumpster doors open. At 3:30 P.M., dumpster panel doors were observed to still be open. In an interview during the environmental tour on 3/15/11 at 1:00 P.M., the Maintenance Supervisor indicated the refuse company emptied the dumpster every day except Sunday and Tuesday. They typically left the doors open, and he had to shut them.			
R0214	(a) An evaluation of the individual needs of each resident shall be initiated prior to admission and shall be updated at least semiannually and upon a known substantial change in the resident ' s condition, or more often at the resident ' s or facility ' s request. A licensed nurse shall evaluate the nursing needs of the resident. Based on observation, interview and record review, the facility failed to complete an evaluation for 2 of 2 residents who had substantial changes in condition with emerging behaviors, in a sample of 10 residents reviewed. [Residents #83 and #105] Findings include: 1. The clinical record for Resident #83 was reviewed on 4/20/11 at 4:44 P.M.	R0214	The Director of Nursing will review each resident's service plan/assessment to ensure all are reflective of the resident's current condition. Resident's #83 and #105 service plans/assessments will be update to reflect thier current condition. The Director of Nursing will inservice all staff who participate in writting service plans or assessments on the proper procedure and regulations concerning documentation of service plans and assessments. Nursing staff will be inserviced that any change of condition	06/05/2011

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	The resident was admitted to the secured/Alzheimer unit from another facility on 12/10/10 with diagnoses that included, but were not limited to, dementia, depression, and hypertension. Incidents reported by the facility to the Long Term Care Division of the Indiana State Department of Health included the following: 12/26/10--"Poured lemonade over Resident [resident's name] head in the dining room prior to breakfast." The residents were separated and their physicians and families were notified. A family member for Resident #83 contacted a physician for follow-up, which included a medication change and urinalysis test for a urinary tract infection. 1/28/11--"Per activity director, resident [#83] pushed her way in room of [other resident's name] and smacked her.... Residents separated. Both residents had visitors on unit. Vital signs checked. M.D. and families notified. [Resident #83] has new M.D. appointment on 2/2/11. No other events reported. [The other resident's name] usually keeps door locked." 2/3/11--"Resident [#83] went into Resident [resident's name] apartment.		should be reported on the 24 hour report. The Director of Nursing will monitor the 24 hour report for both Keepsake Unit and the Assisted Living unit for changes in condition and verify that updated service plans and assessments were done for any resident that has a change in condition. All items to be completed by June 5, 2011.	

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	Maintenance workers walking near room and heard scream--entered room and observed [Resident #83] pull [other resident] out of her wheelchair onto floor and began hitting her." Resident #83 was admitted to an acute hospital geriatric psychiatric unit on 2/4/11. The "Nurse's Notes" progress notes from 12/28/10 through 4/12/11 indicated the following: 1/21/11 at 7:30 P.M.--"Had altercation in main dining room with [other resident's name].... Heard yelling from nurse's station. Altercation unwitnessed." 1/28/11 at 2:40 P.M.--"This resident pushed her way into Room [room number listed] and smacked resident.... Separated...." 2/1/11 at 9:15 A.M.--"Resident attempted to grab dietary cart when busing tables. Removed from area." 2/3/11 at 1:30 P.M.--"... Maintenance worker came to [writer]. Reported this resident [#83] was in room [room number listed]. Maintenance workers was walking near room, found this resident pulling another resident out of her wheelchair and began hitting other resident...."			

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2/4/11 at 11:00 A.M.--"Resident left at 9:00 A.M. with [family member] to [hospital]...."

3/8/11 at 3:45 P.M.--"Resident ambulated ... from car to unit...."

3/8/11 at 8:00 P.M.--"Resident very agitated upon arrival, would not sit down, trashing dining room place settings, throwing glasses on floor, does not listen to directions, wandering aimlessly. Given Ativan [an anti-anxiety medication] and Seroquel [an anti-psychotic medication]. Finally settled down...."

3/9/11 at 11:20 A.M.--"... has been uncooperative with care and difficult to redirect...."

3/9/11 at 12:30 P.M.--"... [family members] arranging a geri-psych [geriatric psychiatric] doctor for behavior issues...."

3/9/11 at 7:00 P.M.--"Constantly on the move, pulling and picking at silverware, anything, tried to run after another resident with knife and fork--deterred by safe [sic]--will not sit down, does not interact with staff, mumbles...."

3/15/11 at 12:10 P.M.--"... Wandering

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	about unit and redirected several times. Going into others apartments and getting their personal care items, soap, powder. Has removed her shoes numerous times...." 3/15/11 at 6:00 P.M.--"... very anxious, sitting down constantly on the floor, refusing to eat food, constantly moving, taking things apart, picking at other residents, makes no eye contact, seems oblivious to other people, doesn't interact with staff or other residents." In an interview on 4/20/11 at 5:10 P.M., L.P.N. #20 indicated the resident had "bizarre" behaviors, and always has had since she has been in facility. The resident was observed at that time standing at the nurse's alcove/station. She was mumbling in a low tone of voice. After a few minutes, she wandered away, and was observed walking around the unit in the hallways. A "Pre-Admission Evaluation" dated 12/7/10 was located in the clinical record. The number rating system used to determine the resident's level of abilities did not address behaviors. A subsequent evaluation, following the substantial changes in her behavior, was not found.			

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During the daily conference on 4/21/11 at 11:30 A.M., the Administrator was given the opportunity to submit documentation/evidence of an evaluation of the resident following the substantial change.

At the final exit on 4/21/11 at 3:20 P.M., no additional evaluation documentation was provided for review. In an interview at that time, the Director of Nursing indicated they had provided "everything" they had.

2. In an interview on 4/19/11 at 9:50 A.M., L.P.N. #1 indicated Resident #105 was having confusion, and was wandering the facility. They were concerned about potential elopement so they moved her to the locked/secured Alzheimer's unit few weeks ago.

The clinical record for Resident #105 was reviewed on 4/20/11 at 9:30 A.M. Diagnoses included, but were not limited to, high blood pressure, C.V.A. [cerebral vascular accident--"stroke"], left sided weakness, cognitive impairment, and osteoporosis.

A "Nursing Summary" dated 4/1/11 indicated the resident was alert, oriented,

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	confused, and had a poor memory with her mental status changing often. A "Service Assessment" dated 11/1/10 indicated "...the resident needs assistance because of cognitive impairment or memory loss... the resident needs redirection for wandering..." A note added to the category for "wandering" indicated the resident wandered at night. A note in the "Comments" section indicated "gets up at night and wanders inside of bldg [building]." The form also indicated that the resident displayed this behavior 2 to 3 times weekly. During the daily conference on 4/20/11 at 4:10 P.M., the D.O.N. [Director of Nursing] was given an opportunity to provide information related to an evaluation of resident's behaviors. In an interview during the exit conference on 4/21/11 at 3:15 P.M., the D.O.N. indicated she had no further documentation/evidence of an evaluation.			

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R0217	(e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services. (5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided. Based on observation, interview and record review, the facility failed to provide a service plan listing the services to be supplied, related to behaviors and falls, for 4 of 4 residents who experienced these issues, in a sample of 10 residents reviewed. [Residents #83, #32, #105 and #C]	R0217	The Director of Nursing will review each resident's service plan/assessment to ensure all are reflective of the services to be supplied to each resident's and that the services address the resdient's current condition. Resident's #83 and #105 service plans/assessments will be update to reflect services offered. The Director of Nursing will inservice all staff who participate in writting	06/05/2011

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	Findings include: 1. The clinical record for Resident #83 was reviewed on 4/20/11 at 4:44 P.M. The resident was admitted to the secured/Alzheimer unit from another facility on 12/10/10 with diagnoses that included, but were not limited to, dementia, depression, and hypertension. Incidents reported by the facility to the Long Term Care Division of the Indiana State Department of Health included the following: 12/26/10--"Poured lemonade over Resident [resident's name] head in the dining room prior to breakfast." The residents were separated and their physicians and families were notified. A family member for Resident #83 contacted a physician for follow-up, which included a medication change and urinalysis test for a urinary tract infection. 1/28/11--"Per activity director, resident [#83] pushed her way in room of [other resident's name] and smacked her.... Residents separated. Both residents had visitors on unit. Vital signs checked. M.D. and families notified. [Resident #83] has new M.D. appointment on 2/2/11. No other events reported. [The other resident's name] usually keeps door		service plans or assessments on the proper procedure and regulations concerning documentation of service plans, assessments, and services offered. The Director of Nursing will monitor the 24 hour report for both Keepsake Unit and the Assisted Living unit for changes in condition and verify that updated service plans and assessments were done and that they reflect the services needed for that resident. All items to be completed by June 5, 2011.	

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	locked." 2/3/11--"Resident [#83] went into Resident [resident's name] apartment. Maintenance workers walking near room and heard scream--entered room and observed [Resident #83] pull [other resident] out of her wheelchair onto floor and began hitting her." Resident #83 was admitted to an acute hospital geriatric psychiatric unit on 2/4/11. The "Nurse's Notes" progress notes from 12/28/10 through 4/12/11 indicated the following: 1/21/11 at 7:30 P.M.--"Had altercation in main dining room with [other resident's name].... Heard yelling from nurse's station. Altercation unwitnessed." 1/28/11 at 2:40 P.M.--"This resident pushed her way into Room [room number listed] and smacked resident.... Separated...." 2/1/11 at 9:15 A.M.--"Resident attempted to grab dietary cart when busing tables. Removed from area." 2/3/11 at 1:30 P.M.--"... Maintenance worker came to [writer]. Reported this resident [#83] was in room [room number listed]. Maintenance workers was			

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	walking near room, found this resident pulling another resident out of her wheelchair and began hitting other resident...." 2/4/11 at 11:00 A.M.--"Resident left at 9:00 A.M. with [family member] to [hospital]...." 3/8/11 at 3:45 P.M.--"Resident ambulated ... from car to unit...." 3/8/11 at 8:00 P.M.--"Resident very agitated upon arrival, would not sit down, trashing dining room place settings, throwing glasses on floor, does not listen to directions, wandering aimlessly. Given Ativan [an anti-anxiety medication] and Seroquel [an anti-psychotic medication]. Finally settled down...." 3/9/11 at 11:20 A.M.--"... has been uncooperative with care and difficult to redirect...." 3/9/11 at 12:30 P.M.--"... [family members] arranging a geri-psych [geriatric psychiatric] doctor for behavior issues...." 3/9/11 at 7:00 P.M.--"Constantly on the move, pulling and picking at silverware, anything, tried to run after another resident with knife and fork--deterred by			

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	safe [sic]--will not sit down, does not interact with staff, mumbles...." 3/15/11 at 12:10 P.M.--"... Wandering about unit and redirected several times. Going into others apartments and getting their personal care items, soap, powder. Has removed her shoes numerous times...." 3/15/11 at 6:00 P.M.--"... very anxious, sitting down constantly on the floor, refusing to eat food, constantly moving, taking things apart, picking at other residents, makes no eye contact, seems oblivious to other people, doesn't interact with staff or other residents." In an interview on 4/20/11 at 5:10 P.M., L.P.N. #20 indicated the resident had displayed "bizarre" behaviors since her admission to the facility. The resident was observed at that time standing at the nurse's alcove/station. She was mumbling in a low tone of voice. After a few minutes, she wandered away, and was observed walking around the unit in the hallways. A "Pre-Admission Evaluation" dated 12/7/10 was located in the clinical record. The number rating system used to determine the resident's level of abilities did not address behaviors.			

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A Service Plan, dated 3/9/11, listed the following in the "Services Provided" section for "Behavioral/Mood Patterns" area of care:

"Can be uncooperative and wanders aimlessly at times. Removes shoes regularly, but usually will leave slipper socks on. Will sit on floor at times."

The actual services to be provided by the facility were not listed.

During the daily conference on 4/21/11 at 11:30 A.M., the Administrator was given the opportunity to submit documentation of a service plan or other evidence related to the services to be provided by the facility for the resident's behaviors.

At the final exit on 4/21/11 at 3:20 P.M., no additional evaluation documentation was provided for review. In an interview at that time, the Director of Nursing indicated they had provided "everything" they had.

2. In an interview on 4/19/11 at 9:50 A.M., L.P.N. #1 indicated Resident #105 was having confusion, and was wandering the facility. They were concerned about

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	potential elopement so they moved her to the locked/secured Alzheimer's unit few weeks ago. The clinical record for Resident #105 was reviewed on 4/20/11 at 9:30 A.M. Diagnoses included, but were not limited to, high blood pressure, C.V.A. [cerebral vascular accident--"stroke"], left sided weakness, cognitive impairment, and osteoporosis. A "Nursing Summary" dated 4/1/11 indicated the resident was alert, oriented, confused, and had a poor memory with her mental status changing often. A "Service Assessment" dated 11/1/10 indicated "...the resident needs assistance because of cognitive impairment or memory loss... the resident needs redirection for wandering..." A note added to the category for "wandering" indicated the resident wandered at night. A note in the "Comments" section indicated "gets up at night and wanders inside of bldg [building]." The form also indicated that the resident displayed this behavior 2 to 3 times weekly. A Service Plan dated 3/4/11 listed the following for "Services Provided" under the section for "Behavioral/Mood Patterns" areas of care: "Up occasionally			

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		A. BUILDING 00 B. WING	04/21/2011

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	during noc [night]. Pleasant and cooperative usually with care." The actual services to be provided by the facility were not listed. During the daily conference on 4/21/11 at 11:30 A.M., the Administrator was given the opportunity to submit documentation of a service plan or other evidence related to the services to be provided by the facility for the resident's behaviors. At the final exit on 4/21/11 at 3:20 P.M., no additional documentation of services to be provided related to behaviors was provided for review. In an interview at that time, the Director of Nursing indicated they had provided "everything" they had. 3. In an interview during the initial tour on 4/19/11 at 9:00 A.M., L.P.N. #5 indicated Resident #32 had recently been having falls almost weekly. She also indicated resident had a diagnosis of Parkinson's disease. The clinical record for Resident #32 was reviewed on 4/19/11 at 1 P.M. Diagnoses included, but were not limited to, osteoporosis, C.O.P.D. [chronic obstructive pulmonary disease], ataxia [loss of full control of bodily movements-			

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	-walking] and gait abnormality. The most recent fall risk assessment completed by facility on 1/17/11 indicated resident was not a high risk for falls. A "Service Assessment" dated 3/16/11 indicated in the category for "Mobility, Transfers, Escort": "...Assistance required with mobility. Transport to and from all meals per wheelchair...." A "Physical Therapy Evaluation & Care Plan" dated 4/4/11 indicated: "... Patient is fall risk especially on uneven surfaces, Mod A [moderate assist] to prevent falls. Unsteady gait pattern, limited balance reaction ability on uneven surfaces without assistive device. More so when fatigues... Decreased safety awareness. Increased intentional tremor on upper extremities upon fatigue. Unable to demonstrate all three balance strategies, max to mod [maximum to moderate] assist needed to prevent fall without assistive device...." The evaluation indicated resident was a high risk for falls and had decreased ability to transfer. Nurse's progress notes indicated that resident had falls on following dates: 12/9/10--fell while trying to use walker and sat for four hours on the floor because her pendant [used as call light for help]			

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	was wrapped around arm of wheelchair. 3/6/11--found on floor in living room by C.N.A. 3/12/11-- slid out of chair and ended up with bruise to her right cheek. 3/21/11--found sitting on floor near couch around midnight and told staff she did not know how she got there. 3/22/11--found in bathroom floor in front of toilet leaning against wall by staff. The note indicated the resident had increased confusion at that time. 3/26/11--found with bruising on right cheek, mid thoracic [upper back], lumbar [lower back] and right hip. On 4/20/11 at 10:30 A.M., the resident was observed walking from the bathroom to her wheelchair. The resident's portable oxygen tank attached to the back of her wheelchair, but she did not have the nasal canula on. The resident was also observed to not have her "call" pendant on. The resident indicated at that time that she did not need the oxygen or the pendant. The resident indicated she needed to "go" because she had a hair appointment. The resident started to propel herself down the hallway in her wheelchair. When she had traveled 30 feet, she became tired and requested assistance from maintenance supervisor to take her downstairs for her appointment. The most recent service plan, dated			

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	2/15/11, listed the following in the "Services Provided" sections: "Mobility/Transfers" area of care: "Transfers herself in and out of wheelchair, but needs assist with transports. Fall risk--moderate." "Behavioral/Mood Patterns" area of care: "No problematic behaviors." "Other" area of care: "Oxygen in apartment. No interventions needed." The actual services to be provided by the facility related to falls and behaviors were not listed. During the daily conference on 4/21/11 at 11:30 A.M., the Administrator was given the opportunity to submit documentation of a service plan or other evidence related to the services to be provided by the facility for the resident's falls and behaviors. At the final exit on 4/21/11 at 3:20 P.M., no additional documentation of services to be provided related to falls and behaviors was provided for review. In an interview at that time, the Director of Nursing indicated they had provided "everything" they had.			

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	4. In an interview during the initial tour on 4/29/11 at 10 A.M., the Director of Nursing indicated Resident #C had confusion and falls, and recently began receiving Hospice services. The clinical record for Resident #C was reviewed on 4/21/11 at 6:30 A.M. Diagnoses included, but were not limited to, Alzheimer's disease, hypertension, and glaucoma. A. A "Nurse's Note" dated 3/22/11 indicated the resident was "... found in bed with large amt [amount] of undigested vomit. Can hear poss [possible] aspiration with and without stethoscope. Rales bil. [bilateral--both sides] upper and lower posterior lungs. Called [name of radiology service] for chest x ray to rule out aspiration. Question if resident had TIA [transient ischemic attack]. Nonfocusing eye contact for about 2 minutes then became more alert...." The Nurses Admission Assessment dated 3/27/11 indicated the resident had aspiration pneumonia. Physicians orders indicated that the resident was changed on 3/27/11 to a "...dysphagia diet chopped nectar thick liquids..." B. The nurse's notes also indicated falls for Resident #C as follows: 11/6/10--The Receptionist witnessed resident trying to sit down in a chair, but			

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	she missed and accidentally sat on floor. No injuries noted. 11/12/10--A C.N.A. was giving care when resident backed away from her and fell backwards. A small amount of redness was noted to left side. 11/30/10--Resident #C was found in her room, sitting on floor on her buttocks at the foot of her bed. No injuries were noted. 1/18/11--The resident was found on the floor, laying on her back. She told staff she was trying to go to the bathroom. No injuries were noted. 3/1/11--The resident was found sitting up on the floor, inside her room door. No injuries were noted. 4/2/11--The resident was found on floor in hallway, and told staff she had hit her head. Neurological checks and vital signs were done. A "Fall Assessment" completed on 3/2/11 indicated that the resident was at high risk for falls. The most recent service plan, dated 3/2/11, listed the following in the "Services Provided" sections: "Mobility/Transfers": "Ambulates independently. Monitored due to gait			

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	unsteady at times" "Nutritional Status": "Appetite fair to good. No current order for Boost. Resident does not like to drink Boost. Enjoys snacks et [and] Coca Cola." The actual services to be provided by the facility related to falls and swallowing problems were not listed. During the daily conference on 4/21/11 at 11:30 A.M., the Administrator was given the opportunity to submit documentation of a service plan or other evidence related to the services to be provided by the facility for the resident's falls and swallowing. At the final exit on 4/21/11 at 3:20 P.M., no additional documentation of services to be provided related to falls and swallowing was provided for review. In an interview at that time, the Director of Nursing indicated they had provided "everything" they had.			

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R0306	(g) Medications administered by the facility shall be disposed in compliance with appropriate federal, state, and local laws, and disposition of any released, returned, or destroyed medication shall be documented in the resident ' s clinical record and shall include the following information: (1) The name of the resident. (2) The name and strength of the drug. (3) The prescription number. (4) The reason for disposal. (5) The amount disposed of. (6) The method of disposition. (7) The date of the disposal. (8) The signature of the person conducting the disposal of the drug. (9) The signature of a witness, if any, to the disposal of the drug. Based on interview and record review, the facility failed to ensure proper documentation of and destruction of a Schedule II controlled drug called Ativan. This affected 1 of 1 residents receiving Ativan in a sample of 10 residents reviewed. [Resident #C] Findings include: During the initial tour on 4/29/11 at 10 A.M., the DON indicated that Resident #C had confusion, falls, and was receiving Hospice services The clinical record for Resident #C was reviewed on 4/21/11 at 6:30 A.M. Diagnoses included, but were not limited to, Alzheimer's disease, hypertension, and	R0306	The procedure for administering crushed medicines will be changed to seperate controlled schedule drugs from other drugs being administered. Controlled drugs will be crushed independantly so they can be disposed of using proper procedures which includes two nurses to witness the destruction. The nursing staff will be inservices as to the proper procedure for destruction of controlled drugs.	06/05/2011

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	glaucoma. The M.A.R. [Medical Administration Record] for February and March, 2011 indicated the resident had refused her medications several times. The medication Ativan was refused and not documented on the MAR on the following dates: February: 5th, 6th, 8th, 15th, 19th, and 22nd. March: 5th, 7th, 10th, 11th, 15th, 17th, 28th, 30th and 31st. There was no documentation related to the destruction of Ativan after it was refused by the resident for the previously listed dates. In an interview on 4/21/11 at 11:10 A.M., after she had reviewed the February and March MARs, L.P.N. #1 indicated the refused medications were not documented on the MAR as they should have been. She also indicated she was not aware that two nurses were required to document the date, time, and method of destruction of a Schedule II controlled substance. The nurse indicated they did not use any forms to document the destruction of a controlled substance. This Residential rule relates to Complaint Number IN00086625.			

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